STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

MARKET CONDUCT EXAMINATION

AND

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

VOLUNTEER STATE HEALTH PLAN, INC.

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1 THROUGH MARCH 31, 2000

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DATE: August 31, 2001

A limited market conduct examination of claims processing and a limited scope financial and compliance examination of Volunteer State Health Plan, Inc., 801 Pine Street, Knoxville, Tennessee, 37402-2555, was completed August 11, 2000. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination report "by test" of the claims processing system of Volunteer State Health Plan, Inc. ("VSHP"). A description of the

specific tests applied is set forth in the body of this report and the results of those tests are included herein.

Further, this report reflects the results of the limited scope review of financial statement account balances as reported by VSHP and of VSHP's compliance with certain contractual requirements.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP was conducted by the TennCare Division of the Tennessee Department of Commerce and Insurance ("TDCI") under the authority of Section 3-6. of the TennCare contract between the State of Tennessee and VSHP, Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

VSHP is licensed as a health maintenance organization ("HMO") in the state and participates by contract with the state as a managed care organization ("MCO") in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of VSHP. Two hundred claims were selected for testing from paid and denied claims processed by VSHP from January 1, 2000, through March 31, 2000. The fieldwork was performed from July 31, 2000, through August 11, 2000.

The limited scope financial examination focused on the balance sheet and income statement as reported by VSHP on its NAIC Quarterly Statement for the period ended March 31, 2000.

The limited scope compliance examination focused on VSHP's member appeals and complaints procedures, review of provider agreements and subcontracts, and demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's operations were administered in accordance with the TennCare Contract as well as State statutes regulating HMOs and that VSHP TennCare members are ensured of the uninterrupted delivery of health care services on an on-going basis.

The objectives of the examination were to:

- Determine whether VSHP met its contractual obligations under its Contractor Risk Agreement with the State (the "TennCare Contract") and whether VSHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. §§ 56-32-201 et seq.;

- Determine whether VSHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether VSHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether VSHP had implemented a complaint/appeals system to reasonably resolve complaints/appeals for TennCare members in a timely manner; and

- Determine whether VSHP had corrected deficiencies outlined in prior reviews of VSHP conducted by the Comptroller of the Treasury ("Comptroller") or examinations conducted by TDCI.

III. PROFILE

A. Brief Overview

Volunteer Sate Health Plan II, Inc., ("VSHP2"), a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. ("BCBST"), was chartered as a for-profit corporation in the State of Tennessee on July 11, 1996, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. On November 8, 1996, by way of the Articles of Amendment to the Charter, Volunteer State Health Plan II, Inc., changed its name to Volunteer State Health Plan, Inc. Also on November 8, 1996, TDCI granted VSHP a certificate of authority to operate as an HMO in all community service areas ("CSAs") except the Knox County and the East Tennessee CSAs.

On January 1, 1998, VSHP merged with Volunteer State Health Plan-Eastern Tennessee, Inc., ("VSHP-ET"), a not-for-profit corporation also wholly-owned by BCBST. VSHP-ET was a licensed HMO that participated in the TennCare Program in only the Knox County and East Tennessee CSAs. VSHP was the surviving corporation after the merger

was completed. After the merger of VSHP and VSHP-ET, VSHP provided coverage to TennCare enrollees on a statewide basis.

VSHP derives the majority of its revenue in the form of capitation payments from the state for providing medical benefits to TennCare members. As of March 31, 2000, VSHP reported 613,292 TennCare members. VSHP is also known as "BlueCare".

B. Claims Processing Not Performed by MCO

VSHP subcontracts with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- AdvancePCS, Inc., as its pharmacy claims processing vendor; and
- Doral Dental of Tennessee, Inc. for dental services.

Because subcontractors process the claims for these benefits, claims for these types of services were not included in the population of VSHP claims from which 200 claims were selected for detailed testing. The claims processed by subcontractors were analyzed only for compliance with timely processing requirements of Section 2-18. of the TennCare Contract.

IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing and internal control deficiencies cited in the financial and compliance review report by the Comptroller of the Treasury, Division of State Audit, for the period January 1, 1996, through December 31, 1998, released March 3, 2000.

Discrepancies in Claims Processing:

VSHP did not fulfill contractual claims processing requirements.

- Six claims were improperly denied.
- One claim was processed under the wrong provider number.
- One claim resulted in an incorrect payment as the result of an incorrect procedure code.
- VSHP inadequately reported encounter data to the TennCare Bureau.
- Copayment and deductibles were not always properly calculated.

VSHP's written response to the Comptroller's Report:

The errors regarding the improper denial of claims for enrollees with other insurance appear to have resulted from keying errors. However, due to the unique procedures associated with the processing of TPL claims, and the loading of TPL information received from the State, BlueCare consolidated the processing of this claim type into one department in 1998. This

consolidation has resulted in more efficient and accurate processing as claims associates receive TPL specific training.

Due to system limitations of our pharmacy vendor, we developed a deductible split based on historical cost-sharing data. The process was developed due to the timing and coordination involved between two systems to minimize or eliminate the potential of over-applying deductible amounts. We were aware this was not a perfect process, but in all instances the member would not be disadvantaged. This process is monitored and tracked on a daily basis to ensure members are not overcharged.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Claims Processing Market Conduct Examination

The following deficiencies were found when testing 200 claims selected from the population of claims processed by VSHP during the period January 1, 2000, through March 31, 2000:

1. VSHP did not process 100% of all claims within 60 days of receipt.

2. Two of 44 denied claims did not reflect all denial reasons.

3. The coinsurance or deductible was not properly calculated on two claims.

4. The data reported on two claims was not correctly entered into the claims processing system.

5. The Claims Status Report submitted to TennCare on a weekly basis was not prepared correctly.

6. Adequate documentation was not maintained for all provider complaints.

7. Control of incoming claims was not established immediately in the mailroom.

B. Summary of Deficiencies – Limited Scope Financial and Compliance Examination

The following deficiencies were determined to exist during the limited scope examination of VSHP for the period January 1, 2000, through March 31, 2000:

1. Outstanding checks were incorrectly reported as a liability.

2. Claims Payable was significantly overstated.

VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING

A. Claims Selected For Testing

VSHP provided a data file of claims processed (paid and denied) during the period January 1, 2000, through March 31, 2000. The total amount paid per the data file was reconciled to the VSHP general ledger for the period January 1 through March 31, 2000, to within an acceptable level. For each claim processed the data file included the date received, date paid and, if applicable, amount paid. From the data file, 200 claims were randomly selected using a random number generator.

B. Julian Date Testing

A Julian date was assigned to each incoming claim to indicate the date the claim was received. Julian dates were tested to ensure that claims were being aged accurately for timeliness reporting. Ten (10) claims were randomly selected from a batch of incoming mail on August 2, 2000. By August 11, 2000, all ten (10) claims had been entered into the claims processing system with correct received date.

C. Time Study of Claims Processing

1. The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames required by Section 2-18. of the TennCare Contract and Tennessee Code Annotated § 56-32-226(b) (the "Prompt Pay Act"). Section 2-18. of the TennCare contract requires an MCO to process 95% of "clean" claims within 30 calendar days of receipt, the remaining 5% of "clean" claims within the next 10 calendar days, and 100% of *all* claims ("clean" or not "clean") within 60 calendar days of receipt. A "clean" claim is defined as a claim which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the MCO. The term "process" means that the MCO must either:

   - Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

   - Deny the claim, with ***all specific reasons*** for the denial communicated to the provider; or

   - Advise the provider that there is insufficient information to adjudicate the claim and detail the *specific* information needed to adjudicate the claim.

The Prompt Pay Act requires that 90% of clean claims be processed, and if appropriate paid, within 30 days of receipt and that 99.5% of all provider claims be processed within 60 days of receipt.

The processing and efficiency requirements of the TennCare Contract were applied to the 200 claims tested. For denied claims, the date that the provider remittance advice was printed was considered the final process date. Paid claims correctly reflected the provider remittance date as the final process date.

The timeliness testing applied to the 200 selected claims found that VSHP processed all claims within 60 days of receipt.

Because the 200 claims tested were not selected using a statistical sampling method, the results of the timeliness tests for processing "clean" claims could not be projected to the total population of claims processed by VSHP during the period January 1, 2000 through March 31, 2000. Therefore, it was not determined whether VSHP complied with the TennCare Contract's requirement by processing 95% of "clean" claims within 30 days of receipt and the remaining 5% of "clean" claims within the next 10 days of receipt during the test period.

2. After the on-site examination of VSHP, TDCI requested a data file from all MCOs, including VSHP, which contained **all** original claims processed during the month of January 2001. TDCI used this data file to determine each MCO's compliance with the processing requirements defined in the TCA § 56-32-226(b) and Section 2-18 of the TennCare Contract by calculating the processing time lag based on the claims' received and processed dates. Because these tests were performed on all original claims processed in January 2001, projection of the test results to the population was not necessary.

   TDCI's analysis of the claims data file found that, during the month of January 2001, VSHP processed 98.6% of all claims within 30 days and 99.97% of all claims within 60 days.

   The Prompt Pay Act requires that 90% of clean claims be processed within 30 days and that 99.5% of all claims be processed within 60 days. In January 2001, VSHP was in compliance with TCA § 56-32-226(b). VSHP was not in compliance with Section 2-18 of the TennCare Contract that requires 100% of all claims be processed within 60 days, however, because .03% of claims were not processed within 60 days of receipt. Effective July 1, 2001, the timeliness requirements in the TennCare

Contract have been changed to be consistent with those set forth in the Prompt Pay Act.

Management's Comments:

Management concurs with this finding.

D. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

1. In one instance coinsurance and deductibles were still being applied to an enrollee's claims even though that enrollee had met his maximum out-of-pocket liability. Per VHSP, this was the result of a programming problem in the Amisys system. When a certain set of conditions were met, Amisys would continue to deduct coinsurance from the providers' payments even though the enrollee had met his out-of-pocket maximum liability. Per VSHP, a report was run monthly to identify those individuals who had exceeded the maximum out-of-pocket expenditures and the enrollee was reimbursed for the excess. The claim tested was processed on February 25, 2000. As of the end of fieldwork on August 11, 2000, this particular enrollee had not been reimbursed.

2. The Amisys system did not correctly accumulate the deductible for uninsured or uninsurable enrollees subject to the deductible. VSHP arbitrarily assigned $175 of the $250 deductible to the medical claims processed by VSHP and the remaining $75 to pharmacy claims processed by AdvancePCS. There was no coordination of benefits between the two deductible accumulators. An enrollee could satisfy one allocated deductible and receive 100% benefits on subsequent claims without being assessed the total $250 deductible as required by the TennCare Contract. During the testwork it was noted that one enrollee met the $175 deductible allocated to medical claims but not the $75 deductible allocated to pharmacy claims. This enrollee received additional medical services, but VSHP did not apply any of the remaining deductible to the claims when processed. Because of the lack of coordination of benefits between the two deductibles, VSHP overpaid these claims.

Management's Comments:

Management concurs with this finding.

E. Withhold, Deductible and Coinsurance Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. No discrepancies were noted during the examination.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments on certain procedures, whether out-of-pocket payments are within liability limitations, and whether out-of-pocket payments are accurately calculated in accordance with Section 2-3.k. of the TennCare Contract.

   Five claims to which coinsurance was applied were selected for testing. The coinsurance was correctly calculated and the accumulation of the enrollees' out-of-pocket costs was computed accurately.

F. Suspended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been suspended or pended by VSHP, the principal reasons for the suspended claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. The reports of claims "in process" contained no claims outstanding for more than 60 days. It was noted that these reports contained no claims that were in adjustment status. VSHP explained that adjusted claims were not included in the count of claims in process because a "re-open" or "adjust" date was not assigned to these claims. Instead, Amysis reported the original received date for the adjusted claims. VSHP asserts that the inclusion of previously adjudicated claims which were then being adjusted would cause the calculation of days "in process" to be overstated.

Management's Comments:

Management concurs with this finding.

G. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices.

VSHP provided EOBs to enrollees whose claims were subject to deductible and coinsurance. The EOBs corresponding to the five claims tested for correct deductible and coinsurance calculation were requested for review. No discrepancies were noted.

H. Remittance Advice Testing

The purpose of testing remittance advices is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

Five remittance advices were compared to the information in the claims system and no errors were found.

I. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the payment of claims by VSHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

Five checks were selected for testing. All 5 checks cleared through the bank account within a reasonable time after the issue date.

J. Comparison of Actual Claim with System Claim Data

The purpose of comparing the data on the hard copy claims to the data entered into the claims system is to ensure that the claims data received by VSHP is accurately entered into the claims system. Data must be entered accurately to ensure that claims are adjudicated appropriately and that encounter data is reported correctly to the TennCare Bureau.

The examiners requested hard copies of the 200 claims selected for testing. VSHP provided 93 claims. The remaining claims had been electronically submitted by providers, thus, VSHP could only produce a printout from the computer system for these claims. The data elements reported on the 200 claims were compared to the data elements entered into VSHP's claims processing system. Results of the comparison are as follows:

1. One claim was entered into the Amisys system with the wrong date of service.

2. An enrollee's Social Security number was entered incorrectly for one claim.

Management's Comments:

Management concurs with this finding.

K. Electronic Claims Capability

Section 2-18 of the TennCare Contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted

electronically with the exception of claims that require written documentation to justify payment …". Section 2-2.g. of the TennCare Contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. VSHP has implemented an electronic billing option for claims submission by providers. In fact, 53.5% of the claims selected for review had been submitted electronically.

L. Weekly Claims Processing Reports

The July 31, 2000 weekly claims processing report was selected for review and VSHP was requested to provide supporting documentation for this report. The following deficiencies were noted in the weekly claims processing report:

1. Not all claims in VSHP's system are accounted for on the weekly claims status report. Claims which have been received for adjustment and/or reprocessing and subsequently loaded into the claims processing system are not included in the total reported for the aging of "claims input but not adjudicated."

2. The average turnaround time for VSHP's adjudicated claims is inaccurate because the claims mentioned above are not included in the calculations.

3. Counts reported for the pharmacy and dental claims are obtained from the subcontractors and are not reconciled to claims processing information in VSHP's data warehouse. A review of claims status reports for the period January 1, 2000 through March 31, 2001, revealed no pharmacy or dental claims being reported as processed in excess of 60 days; however, a review of the actual claims information submitted to VSHP's data warehouse for the same period revealed that 24,553 of 3,333,008 (0.7%) pharmacy and dental claims were processed in excess of 60 days.

Management's Comments:

Management concurs with the finding.

1. It was our interpretation that the adjustments should not be included in the timeliness calculation as outlined in Section 2-18 of the TennCare contract due to the nature of how adjustments are received for processing. Our understanding of the original intent of this report was to report volume of pended original claims received for the week. Based on the meeting with the TDCI on August 23, 2001, adjustments are expected to be included on this report. We are in the process of developing a report to track the pended adjustments in this manner and will begin reporting this data on future Weekly Claims Processing Reports.

2. See the above response.

3. We have reviewed the data you provided during the meeting on August 23, 3001. Our research shows that this problem is primarily associated with long-term care pharmacy claims ("LTC") which are forwarded to us on a monthly basis. There were approximately 20,264 claims that fell into this category. We are in the process of evaluating our pharmacy vendors who handle our LTC business. Approximately 3,951 claims appear to be the result of a Y2K problem. The received date on these records was listed incorrectly as 1900. The remaining 338 records were identified as claims received from our dental subcontractor Doral Dental. We are currently discussing with Doral their procedures for handling adjustments.

M. Provider Complaints to TDCI Regarding Claims

VSHP documentation of the resolution of provider complaints was inadequate. Ten (10) provider complaint files were selected from VSHP's provider complaint log. For one complaint, VSHP was unable to provide documentation that the provider had been notified of VSHP's decision on the complaint.

Management's Comments:

Management concurs with this finding.

N. Weaknesses in Mail Room Controls

VSHP did not establish immediate control of claims received in its mailroom. TennCare claims received in the mailroom were sorted from the commercial claims and placed in large mail cartons. Once a carton was full, it was labeled as "TennCare" and given to Internal Transportation for delivery to the BlueCare Support Department. Claims were neither counted nor assigned a claim number until they were received in department. Because TennCare claims were processed in a different building, they must be transported by truck to the processing site. If claims were to be lost or misplaced in transit, there would be no record of receiving the claim.

Management's Comments:

Management concurs with this finding.

On December 1, 2000, we implemented a new process of imaging all HCFA –1500 claims and on March 30, 2001, we began imaging electronically filed UB92 claims received on or after this date. The target date for imaging all UB92 claims is November 1, 2001. The new imaging software allows us to enter all paper claims into our

processing system within one day of receipt while creating a permanent image of the claim and attachments. Additionally, the claims are imaged in the mailroom upon receipt. These images will be used by claims processors and customer service representatives to finalize claims and answer questions. This new process should eliminate any concern of claims being transported by truck to the processing site.

VII. DETAIL OF TESTS CONDUCTED – FINANCIAL AND COMPLIANCE REVIEW

A. Analysis of Account Classification

During the examination, each account on the First Quarter 2000 NAIC Quarterly Statement was reviewed to determine if it was properly classified. It was noted that VSHP reported the account balance for "Outstanding Checks in Excess of Bank Balance" as a liability. This account represents the checks written by VSHP that have not been presented to the bank. VSHP reported this account as a Miscellaneous Liability rather than as a reduction to cash. Per instructions from the NAIC, all outstanding checks are to be reported as a reduction in cash even if the result is a negative cash balance.

TDCI noted that VSHP correctly reported the balance of "Outstanding Checks in Excess of Bank Balance" as a reduction to cash on its Third Quarter 2000 NAIC Quarterly Statement.

Management's Comments:

Management concurs with this finding.

B. Review of Account Balances

As part of the examination, account balances reported on the First Quarter 2000 NAIC Statement were reviewed to determine if they were properly documented. Transactions subsequent to the examination period were also reviewed to determine if significant changes in accounting estimates as of March 31, 2000 were necessary.

Nothing came to the attention of TDCI to indicate that the amounts represented on the financial statements were not valid at the time the statements were prepared. An analysis of claim-related payments made after the First Quarter 2000 NAIC Statement was prepared revealed that the claims payable balance reported at March 31, 2000 was significantly overstated. This overstatement of claims payables resulted in a VSHP reporting a significant operating loss.

On its First Quarter 2000 NAIC Statement, VSHP reported Claims Payable of $120,389,556 and Net Worth of $54,238,767 as of March 31, 2000 and a Net Loss before income taxes of $22,299,448 for the three months ended March 31, 2000.

On its Second Quarter 2000 NAIC Statement submitted to TDCI on September 1, 2000, VSHP reported Claims Payable of $110,556,640 and Net Worth of $50,907,057 as of June 30, 2000 and a Net Loss before income taxes of $23,801,863 for the six months ended June 30, 2000. As a result of information that came to the attention of TDCI during the examination, VSHP amended its Second Quarter 2000 NAIC Statement to correct the overstatement of Claims Payable and report the effect of other subsequent events on April 6, 2001. These adjustments made by VSHP included a $26,161,685 reduction in Claims Payable and a $4,916,41*3* reduction in Admitted Premiums Receivable. After amendment, VSHP's Second Quarter 2000 NAIC Statement reported that Claims Payable decreased to $84,394,955 and Net Worth increased to $66,182,776 as of June 30, 2000 and VSHP had Net **Income** before income taxes of $784,988 for the six months ended June 30, 2000.

Management's Comments:

Management concurs with this finding.

Changes to the Outstanding Claims Liability (OCL) as of March 31, 2000 were required. The March OCL estimate was calculated using historical Per Member Per Month (PMPM) numbers with the associated trend and seasonality numbers. However, the closure of TennCare enrollment in VSHP in December 1999 had a significant impact on projected PMPM's for the first quarter 2000 that was not anticipated in the calculation. Because VSHP providers are allowed 180 days to bill claims to VSHP, it was not until the third quarter of 2000 that the full impact of enrollment closure on VSHP medical expenses for the first quarter was validated by the claims run-out data.

Additionally, VSHP assumed liability for medical services provided to members in the Knox and East Tennessee Community Service Areas effective January 1, 2000. Previously, these services were being paid through its subcontractor, THP, based on THP's provider network contracts. First quarter 2000 OCL assumed VSHP payment patterns comparable to THP's during 1999. However, subsequent analysis indicated that payments under the VSHP network were lower than the historical cost incurred by THP. This contributed to the overstatement of Outstanding Claims Liability for the period.

VIII. MEMBER APPEALS

Ten (10) enrollee complaints and ten (10) enrollee appeals filed by members during the examination period were selected from VSHP's monthly logs. The supporting documents for

these complaints and appeals were reviewed. It was determined that all of the complaints and appeals were timely resolved and the members were adequately notified of the resolution of the complaint or appeal by VSHP in compliance with Section 2-9 of the TennCare Contract.

IX. PROVIDER AGREEMENTS

Section 2-18 of the TennCare Contract sets forth specific language that must be contained in an MCO's provider agreements. Tennessee Code Annotated §§ 56-32-203(b) and 56-32-203(c) require an HMO's provider agreements, and any material modifications thereto, to be prior approved by TDCI. VSHP has submitted its proposed provider agreements to TDCI for approval and is currently working with TDCI to ensure their compliance.

X. SUBCONTRACTS

Section 2-10 of the TennCare Contract requires all subcontracts, and amendments thereto, to be prior approved by the TennCare Bureau. Tennessee Code Annotated §§ 56-32-203(b) and 56-32-203(c) also require an HMO's subcontracts, and material modifications thereto, to be prior approved by TDCI. During the examination period, VSHP's subcontracts were for the provision of dental services, pharmacy services and management services. The TennCare Bureau confirmed that VSHP had submitted these subcontracts for approval in accordance with Section 2-10 of the TennCare Contract. Furthermore, TDCI had also approved these subcontracts as required by statute.

XI. TITLE VI

Effective July 1, 1996, Section 2-25 of the TennCare Contract requires VSHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act which prohibits discrimination based on race, color or national origin. Based on discussions with various VSHP staff and review of policies and related supporting documentation, it appears that VSHP complies with Section 2-25 of the TennCare Contract.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of VSHP.